BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
MERVAT GAMIL KELADA, M.D.	)	**Case No. 800-2014-006080**
Physician's and Surgeon's Certificate No. A48353	)	**OAH No. 2016100824**
Respondent	)	

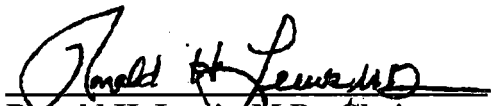
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on December 7, 2017.

IT IS SO ORDERED: November 7, 2017.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MERVAT GAMIL KELADA, M.D., Physician's and Surgeon's Certificate No. A 48353, Respondent.	Case No. 800-2014-006080 OAH No. 2016100824

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Diego, California, on September 12 through 15, 2017.

Joseph E. McKenna, III, Deputy Attorney General, Department of Justice, Office of the Attorney General, State of California, represented complainant, Kimberly Kirchmeyer, Executive Director of the Medical Board of California (board).

Raymond J. McMahon, Attorney at Law, Doyle Schafer McMahon, represented respondent, Mervat Gamil Kelada, M.D., who was present.

The matter was submitted on September 15, 2017.

PROTECTIVE AND SEALING ORDER

The names of the patients in this matter are subject to a protective order. No court reporter or transcription service shall transcribe the actual names of a patient but shall instead refer to the patient by his or her initials, C.A., S.A., G.G., E.T. and C.F.A., which were identified during the administrative hearing and on a Confidential Names List and are used in this proposed decision.

During the hearing, numerous exhibits were admitted into evidence that contain confidential medical information, investigative records, and names of complaining witnesses. It was not practicable to redact this information from these exhibits. To protect privacy and

confidential personal information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued. The order lists the exhibits ordered sealed and governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

SUMMARY

Complainant alleged that respondent was grossly negligent in her care of patient C.A. by erroneously administering a TB test to C.A. when it was not indicated, failing to read the results of that TB test, and failing to document the TB test in C.A.'s medical records. Complainant further alleged that respondent committed repeated negligent acts, including the erroneous administration of the TB test, failing to properly document her care and treatment of patient C.A. and S.A., and disclosing confidential medical records of patients GG., E.T., and C.F.A.to other patients C.A. and S.A. without proper authorization. Complainant further alleged that respondent's record keeping for patients C.A. and S.A. was not adequate or accurate.

Clear and convincing evidence established that respondent violated the standard of care in certain aspects of her care and treatment of the two patients, and in her unauthorized disclosure of confidential medical information. Respondent was grossly negligent in her care of patient C.A., and repeatedly negligent in her care of patients C.A and S.A., and her unauthorized disclosure of confidential medical information. In addition, parts of respondent's records for both patients C.A. and S.A. were not adequate or accurate.

Respondent requires further training and oversight. The public will be adequately protected if respondent's license is placed on probation, she is required to successfully complete a clinical education program that addresses the issues raised in this hearing, completes a recordkeeping course, and complies with the standard terms and conditions of probation consistent with the board's disciplinary guidelines.

FACTUAL FINDINGS

Background and License History

1. On June 18, 1990, the board issued Physician's and Surgeon's Certificate No. A 48353 to respondent, Mervat Gamil Kelada, M.D. The license will expire on June 30, 2018, unless it is renewed or revoked.

2. On September 7, 2016, complainant filed accusation No. 800-2014-006080 against respondent. The accusation alleged four causes for discipline of respondent's license: (1) gross negligence in her care of patient C.A., including performing a tuberculosis

(TB) skin test on C.A. when it was not indicated and failing to have C.A. return for an interpretation of the TB skin test; (2) repeated negligent acts in her care and treatment of patients C.A., S.A., G.G., and E.T., including by providing medical records for patient G.G. to patient C.A. without consent of G.G. and providing medical records for patient E.T. to patient S.A. without consent of E.T.; (3) failure to maintain adequate records regarding her treatment of patients C.A. and S.A.; and (4) general unprofessional conduct.

3. Respondent filed a notice of defense, and this hearing followed.

Respondent's Background

4. Respondent is 60 years old and was born and raised in Egypt. She speaks five languages: Greek, French, English, Spanish and Arabic. In 1982 respondent obtained her medical degree from Alexandria Medical Center in Egypt, where she married her husband. During her time in medical school respondent did a substantial amount of international medicine work with the World Health Organization (WHO) and treated patients in various countries including Egypt, Kenya, Ethiopia, and Sudan. She moved to the United States with her husband in 1983 and worked as a volunteer and did an externship in obstetrics and gynecology at a hospital in Pittsburg, Pennsylvania. She and her husband moved to California in 1984. From 1985 to 1987 she started studies at University of California Los Angeles (UCLA) towards obtaining a Master's Degree in Public Health. From 1987 to 1988 she did an externship in pediatrics at Kerns Medical Center in Bakersfield, California. From 1988 to 1990 she started a residency program in pathology at Kerns Medical Center, which was affiliated with UCLA.

Respondent thereafter decided to switch her field of study to family medicine, and from 1990 to 1993 she did her residency in family medicine at the University of South Alabama Medical Center, which she successfully completed in 1993. Respondent became board certified in family medicine by the American Academy of Family Physicians. During the time she was in Alabama she worked in a lot of emergency rooms in Alabama and Mississippi. She returned to California in 1993 and worked as an attending physician in the emergency room of White Medical Center in Los Angles where she worked for four years. In 1993 respondent accepted the position as the director of the emergency room at Calexico Hospital while also working at White Medical Center. Respondent formed an emergency medicine group to operate the emergency room at Calexico Hospital, which was struggling financially and had not paid many of the physicians working there in some time. In 1995 respondent approached the city of Calexico, who owned the building where Calexico Hospital was located, and leased the building where she started her own clinic in December 1995 called De Anza Clinic. In 1996 she resigned from Calexico Hospital and took the practice group she started with her to the De Anza Clinic. Since 1996 respondent practices family medicine full time in Calexico, California and Brawley, California, which both have an underserved population of primarily poor patients.

5. Respondent has staff privileges with El Centro Regional Medical Center and Pioneer Memorial Hospital in Brawley, California. She has never had her privileges

revoked, suspended, or placed on probation by any hospital with which she has been associated. Respondent has been involved in community health issues in Imperial County and has held numerous leadership positions. Currently, and for the past several years, respondent teaches at Imperial Valley College lecturing to nursing students and has allowed several medical assistant students from Imperial Valley College to train with her in her clinic. Respondent was also appointed as a clinical instructor with University of California San Diego (UCSD) where she had medical residents rotate through her clinic for a three to four year rotation in rural family medicine. Additionally, from 2001 to 2012 respondent worked as a medical consultant for the Medical Board of California in San Jose, California providing medical expertise in disciplinary actions. Respondent has also held positions in the past as a member of the board of directors of El Centro Regional Medical Center. Respondent is well-respected in her community and among her peers.

Complainant's Evidence

TESTIMONY OF PATIENT C.A.

6. C.A. is a student at San Diego State University (SDSU) studying to obtain his Master's Degree in Speech Language Pathology. He intends to work in a hospital setting after graduation. He currently lives in San Diego with his girlfriend, whom he has been dating for the past six years. In June 2014 C.A. lived with his parents in his hometown of Calexico, California, where he attended elementary, middle and high school. In June 2014 C.A. was a professional mixed martial arts (MMA) fighter and had been fighting professionally for about three years. Accordingly, in June 2014 C.A. was in excellent physical condition and would typically train at least three to four times per week at a gym. If C.A. was preparing for a professional fight, he would train every day and multiple times per day at the gym.

7. C.A. first became a patient of respondent after he injured his shoulder and ankle while wrestling about four months prior to his first visit to respondent's clinic. On June 17, 2014, C.A. first visited respondent's clinic, which was located a few blocks from his home. C.A. testified that he did not make an appointment for his first visit, but rather he simply walked into respondent's clinic for medical treatment. He stated that he went to respondent's clinic because his mother was also a patient of respondent and the clinic was close to him. As a result of the fact that he did not make an appointment for his first visit, C.A. waited a few hours to be seen on June 17, 2014. After he checked in with the receptionist, filled out some paperwork, and waited a few hours, a nurse named Eunice Fernandez took him back to an exam room and took his vital signs. C.A. testified that he recognized Eunice Fernandez because he went to high school with her, but he was not friends with her in high school and at the time of his visit in June 17, 2014, did not know her name. C.A. informed Ms. Fernandez and the receptionist that he was in the office because of a shoulder injury and ankle injury. After Ms. Fernandez took his vital signs, C.A. went back to the waiting room to wait for respondent to see him.

Eventually C.A. was brought back into an exam room where respondent was waiting for him for his examination. C.A. testified that he told respondent that he injured his shoulder and ankle while wrestling and could only raise his shoulder to a certain height, which he demonstrated for respondent. C.A. testified that respondent did not examine his shoulder, arm or ankle during the visit and never inquired about his pain associated with the injuries. C.A. testified that respondent never asked him if he was taking any medication for the pain associated with his injuries. C.A. testified that the entire visit with respondent on June 17, 2014, lasted about three to five minutes. C.A. stated that he felt rushed during the visit and that respondent did not have much interest in his injuries. C.A. testified that during this visit respondent never examined any part of his body and never asked him about his heart or heart rate, never asked him about his level of physical activity or overall fitness, never asked him about his joints, chest, abdomen, hearing, throat or vision. C.A. testified that respondent referred him for x-rays of his shoulder and ankle and told him to come back in two to three days for the x-ray results.

8. On June 20, 2014, C.A. went back to respondent's clinic for the results of his x-rays. When he arrived at respondent's clinic on June 20, 2014, C.A. checked in with the receptionist and then waited in the waiting area. C.A. stated that a nurse came to the waiting area and brought him back into the exam area to take his vital signs. After the nurse took his vital signs, C.A. went back to the waiting area to wait for respondent. After about 30 minutes C.A. was brought back into an exam room where respondent was sitting at a desk typing on a computer. C.A. stated that he sat in a chair adjacent to the desk where respondent was typing on a computer and respondent did not say anything to him. C.A. testified that Ms. Fernandez walked into the exam room with a white paper bag and handed it to respondent. C.A. stated that respondent opened the white paper bag, which contained a syringe and a small bottle. While respondent was drawing liquid from the bottle into the syringe, C.A. asked respondent what she was doing. In response, respondent stated that she was preparing a TB test because "you are up for another test." C.A. stated to respondent that he was not there for a TB test but was there to get the results of his x-rays. According to C.A. respondent stated "you need another TB test" and proceeded to grab an alcohol swab, wipe his left arm, and inject him with the TB test. Respondent also told C.A. that he would have to return in a few days to have the TB test results read. C.A. was confused and surprised and did not pull his arm away because he assumed that respondent knew what she was doing. C.A. also stated that the injection happened in a matter of seconds.

According to C.A., respondent was trying to send C.A. on his way out of the clinic, but again C.A. told respondent that he was not in the clinic for a TB test, but rather was there to get the results of his x-rays. Respondent appeared confused and walked out of the exam room to talk to Ms. Hernandez. C.A. then realized that respondent had made a mistake. C.A. testified that respondent then came back into the exam room with a document in her hand and told him that there was no problem with him having another TB test and that it would be good to know whether he had TB or not. Respondent then told C.A. that his x-ray results were normal and that she would send him to a specialist for his shoulder and ankle pain. Respondent walked out of the exam room and on the way out he spoke to Ms. Hernandez in the hallway. C.A. was upset and told Ms. Hernandez that respondent

mistakenly gave him a TB test injection. C.A. stated that Ms. Hernandez seemed surprised and nervous. According to C.A. respondent did not acknowledge to C.A. that she had made a mistake by giving C.A. a TB test injection. Additionally, C.A. stated that once it was determined that respondent gave the TB test injection to C.A. by mistake, nobody in the clinic informed C.A. that he needed to return to have the TB test results read. C.A. stated that respondent did not review his x-ray results with him, but rather simply told him that the results were normal.

9. After C.A. left the exam room and spoke to Ms. Hernandez, C.A. also told the receptionist that respondent had erroneously given him a TB test injection. C.A. stated that he was upset and the staff in the clinic knew he was upset and could hear him, but he was not being loud and he had a calm demeanor. The receptionist provided him with a copy of a referral to see a specialist for his shoulder and ankle. C.A. testified that he was very upset after receiving the TB test injection, and the staff of the clinic was aware that he was upset. C.A. then left the clinic. After leaving the clinic, C.A. looked at the documents provided to him by the nurse for his referral. C.A. noted that the referral document was signed electronically by respondent, and on the back of the pages of the referral was patient information for another patient. Specifically, C.A. stated that the back of the page showed another patient's name (the name was for patient G.G.), date of birth, date of examination, and that patient G.G. received a positive pregnancy test. C.A. stated that the second page of his referral had on the back of the page information for another patient named C.F.A. including the date of birth for C.F.A.

10. C.A. testified that after he left the clinic on June 20, 2014, he had a red bump on his arm where he received the TB test injection and the red bump grew as the days passed. C.A. stated that he has had about two TB test injections prior to his visit to respondent's clinic and was aware of his reaction to a TB test injection. Specifically, he had had a TB test injection from the Imperial County Health Services clinic in the past and has had a positive reaction to the TB test injection on more than one occasion. As a result, he was required to get a chest x-ray to rule out TB as a diagnosis. C.A. testified that after he received the TB test injection on June 20, 2014, the red bump on his arm grew and became much larger. C.A. showed the red bump on his arm to his girlfriend, his girlfriend's sister, his siblings, his parents, and others. C.A. testified that having the red bump on his arm "was a big deal" to him. C.A. stated that he was never contacted by respondent's office after his June 20, 2014, visit and never had the results of his TB test injection from June 20, 2014, read by respondent or any other physician.

11. On June 22, 2014, C.A. went online to find where he could file a complaint with the board regarding respondent because he was upset that respondent had erroneously given him a TB test injection and had given him confidential information of other patients. C.A. filed a complaint with the board by writing a long paragraph regarding the events that happened during his treatment by respondent and submitting it to the board online. The information contained in C.A.'s online complaint to the board was consistent with his testimony regarding his treatment by respondent.

12. After C.A. submitted his complaint to the board, he was interviewed more than once by an investigator for the board. C.A. was interviewed in person and over the telephone. C.A. testified that he was asked by the investigator who the nurse working with respondent was during C.A.'s visits to respondent's clinic. C.A. stated that he knew the nurse because he recognized her from high school, but he did not know her name. C.A. stated that after speaking to the investigator, C.A. investigated the name of the nurse by going onto Facebook searching for his high school friends to determine the nurse's name. C.A. stated that he easily found a photograph of the nurse on Facebook and determined that the nurse was named Eunice Hernandez.

13. C.A. also testified that respondent never charged him for the TB test injection that he was aware. C.A. stated that on the two days he visited respondent's clinic, the clinic was very busy while he was there and there were lots of patients in the waiting room. C.A. also stated that during his visits to respondent's clinic, he never discussed his mother or respondent's treatment of his mother. C.A. testified that during his visits to respondent's clinic, he never told anyone at the clinic that he was a professional MMA fighter, but did tell the nurse that he injured his shoulder wrestling or training. C.A. also stated that he was fairly well known in the community as a professional MMA fighter and his face was on billboards in the area, so he would not be surprised if people in the clinic knew he was a professional MMA fighter. C.A. reiterated that respondent never inquired about his heart, heart rate, head, chest, or any other specific body part.

TESTIMONY OF PATIENT S.A.

14. Patient S.A. is the mother of patient C.A. S.A. testified at the hearing with the assistance of a Spanish language translator. S.A. has been married for 39 years and has five children and three grandchildren. S.A. currently lives in Imperial, California, and is a homemaker. Prior to living in Imperial, California, S.A. and her family lived in Calexico, California.

15. S.A. received treatment from respondent's clinic from September 2012 to September 2014, and she referred her son, C.A., to the clinic for treatment. S.A. stated that she stopped being treated at respondent's clinic because she was handed a letter on her last visit on September 30, 2014, telling her that she could no longer be treated at respondent's clinic. S.A. stated that she first sought treatment at the De Anza Clinic for her high blood pressure. S.A. stated that during the time she was treated by the De Anza Clinic, she was most often seen by respondent's nurse practitioner, May Denjalearn. S.A. did not recall going to the clinic for specific issues, but S.A. admitted that her recollection of her visits to respondent's clinic "were not the strongest." S.A. stated that she was generally treated by Ms. Denjalearn when she visited the clinic and she understood that Ms. Denjalearn was respondent's assistant, but S.A. called her a doctor. S.A. stated that she typically saw Ms. Denjalearn for high blood pressure problems and preferred to and would request to see Ms. Denjalearn because she spent more time with her than respondent. S.A. stated that during the time she was treated at the clinic she was also seen by respondent when Ms. Denjalearn was

not available. S.A stated that when she met with Ms. Denjalearn, the visits "were more detailed" than when she met with respondent.

S.A.'s memory of her treatment by respondent was fragmented. S.A. did not recall visiting the clinic in October 2012 for a referral to an optometrist, but stated that it could have happened. S.A. further stated that she did not recall ever answering questions about her general health to respondent. While S.A. remembered some visits to respondent's clinic based on her symptoms, she generally had no recollection about the specifics of any examination performed during those visits. S.A. testified that she recalled visiting respondent's clinic complaining of memory problems and she recalled having some studies done on her head as a result. S.A. recalls being referred to a number of specialists during the time she was treated at respondent's clinic, but does not recall the specifics of those treatments. S.A. testified that when she visited respondent's clinic, she sometimes made an appointment prior to the visit and sometimes she simply walked in to the clinic to be seen. S.A. stated that each time she went to respondent's clinic it was always very busy with lots of patients.

16. S.A. testified that she did recall her last visit to respondent's clinic on September 30, 2014. S.A. recalled meeting with respondent during that visit and discussing the medications she took. Specifically, she recalled telling respondent that she had been taking medication for her high blood pressure, but that she forgot to take one dose of that medication on one day. S.A. stated that respondent seemed annoyed that S.A. forgot to take her medication that one day. S.A. testified that at the end of her visit on September 30, 2014, a female employee of respondent handed her a letter from respondent. The letter dated September 30, 3014, stated in both English and Spanish as follows:

> This letter is to inform you that as of today you have 30 days to find a new medical provider as Dr. Kelada will no longer be able to be your primary care physician due to your unwillingness to comply with medical policies and procedures. Listed below are physicians in the area that may be able to meet your medical needs. Thank you.

S.A. testified that she was shocked to receive this letter from respondent.

17. S.A. testified that she was aware that her son had filed a complaint against respondent with the board. She stated that her son did so because respondent gave him an injection mistakenly. S.A. recalls seeing C.A.'s arm where the injection was given and saw a "red welt" on his arm. S.A. stated that this incident happened during the time C.A. was living with her in Calexico.

TESTIMONY OF SOFIA FELICITAS CAMACHO

18. Sofia Felicitas Camacho is the girlfriend of C.A. and has been his girlfriend for the past seven years. Ms. Camacho and C.A. recently started living together, but have

seen each other almost daily since they began dating. During 2014, Ms. Camacho saw C.A. daily. Ms. Camacho testified that she recalls that in 2014 C.A. told her that he received a TB test injection from respondent and it was a mistake. She stated that C.A. was very upset and mad about receiving the mistaken TB test injection, particularly as he had visited respondent for a problem with his shoulder. Ms. Camacho stated that she saw C.A. on the same day he received the TB test injection, although she did not recall the exact date. She stated that she saw C.A.'s arm soon after his appointment with respondent and saw that he had a "red mark" on his arm in the place where C.A. told her he received the mistaken TB test injection. Ms. Camacho stated that she saw the red mark on C.A.'s arm the day after he received the mistaken TB test and the red mark was bigger and more of a bump. She stated that on the third day she saw the red bump it was even bigger. Ms. Camacho stated that the red mark on C.A.'s arm was small on the first day and about the size of the injection site plus "a little inflammation," but the mark progressively got bigger over the next few days up to the size of a nickel and was gone within a week or so.

19. Ms. Camacho testified that she knew that C.A. had made a complaint regarding respondent to the board because of the mistaken TB test. Ms. Camacho also stated that she was interviewed by an investigator for the board. Ms. Camacho stated that she did not recall telling C.A. that he should have the red bump on his arm checked out by a doctor, but that she may have told him that.

TESTIMONY OF PALOMA CAMACHO

20. Paloma Camacho is Sofia Camacho's sister. Paloma Camacho is also a nurse practitioner and has been since February 2017 after receiving her Master of Science Degree in Nursing in December 2016. Prior to becoming a nurse practitioner, Paloma Camacho worked as a registered nurse since December 2010. Paloma Camacho worked as a registered nurse in 2014 during the time C.A. was treated by respondent. She testified that she knows C.A. very well because he is her sister's boyfriend.

21. Paloma Camacho stated that C.A. told her that he received a TB test injection from respondent by mistake. She testified that she saw a red bump on his left forearm where C.A. stated he received the TB test injection. She also stated that the location of the red bump was consistent with her knowledge of where a TB test injection would be given to a patient, and the red bump she saw was also consistent with what she has seen on other patients who have a positive reaction to a TB test injection. Paloma Camacho is familiar with TB test injections and what a positive response to a TB test injection looks like from her work as a nurse. She stated that she did not advise C.A. to follow up on the TB test injection.

TESTIMONY OF JAMES HOWARD SCHULTZ, M.D.

22. Dr. James Schultz has been licensed to practice medicine in California since 1988. He received his Bachelor of Science degree in Biology in 1981 from California State University Dominguez Hills. Dr. Schultz received his Doctor of Medicine degree in 1985 from the University of California Los Angeles (UCLA) School of Medicine. He completed

his residency in family medicine in 1988 at the Tallahassee Memorial Regional Medical Center in Tallahassee, Florida. Dr. Schultz is board certified in family medicine and has practiced family medicine at Graybill Medical Group in Escondido, California since 1988. However, in 2001 Dr. Schultz became the Chief Medical Officer of Neighborhood Healthcare, a primary care community clinic in Escondido, California, which is his primary job. Additionally, since 2003 Dr. Schultz has been a voluntary clinical professor in the Department of Family and Preventative Medicine at University of California San Diego (UCSD). Dr. Schultz also works a couple of shifts per month providing patient care in a hospital setting at Palomar Medical Center, where he is currently the chair of the Department of Family Medicine. He holds hospital privileges at Palomar Medical Center. Since 2007 Dr. Schultz has worked as an expert medical reviewer for the board. He has acted as an expert witness for the board in one or two cases per year and has not worked as an expert witness in any capacity other than for the board. Dr. Schultz provided his expert opinion in this matter after having reviewed information provided to him by the board and he summarized his findings in his report. Dr. Schultz testified that since 2001 his practice has changed from 100 percent clinical patient care to 30 percent clinical patient care with the remaining 70 percent of his time devoted to oversight of Neighborhood Healthcare as the Chief Medical Officer.

23. Dr. Schultz testified that he is familiar with the standard of care in the family medicine community in California. Specifically, he stated that the standard of care is what a reasonable, prudent physician would do in similar circumstances including what conclusions they would reach, what tests they would perform, and what treatments they would provide. Dr. Schultz stated that his understanding of the standard of care in family medicine in California comes from his work as a practicing family medicine physician, his supervision of other physicians, and his role as a chief medical officer where he is responsible for the quality of care given to about 65,000 patients in California. Dr. Schultz testified that he spends a lot of his time making sure that the quality of care received by those patients is the best it can be. Dr. Schultz testified that he understand that a simple departure from the standard of care would be a situation where most reasonable, prudent physicians in similar circumstances would not provide the same care provided. He stated that an extreme departure from the standard of care would be a situation where no reasonable, prudent physician would provide the same care provided in similar circumstances.

24. As part of his review of this matter Dr. Schultz reviewed the medical records from the De Anza Clinic for patients C.A., S.A., G.G., C.F.A., and E.T., the investigative report from the board, correspondence from respondent and her staff to the board, transcripts of interviews of respondent and Ms. Fernandez, and other documents.

TREATMENT AND DOCUMENTATION FOR PATIENT C.A

25. With regard to the treatment of patient C.A. by respondent at her clinic, Dr. Schultz reviewed all of C.A.'s medical records from the De Anza Clinic. Dr. Schulz noted that C.A. was first seen at respondent's clinic on June 17, 2014, for right shoulder injury and left ankle pain from an injury occurring about four months prior to June 17, 2014. Dr.

Schulz testified that the medical records show that C.A. was seen by respondent on June 17, 2014, and that his vital signs were taken showing that C.A. had a heartrate of 47 beats per minute and a body mass index (BMI) of 31.31. Dr. Schultz explained that this heartrate is lower than what is expected for most patients, and a normal heartrate is from 60 to 100 beats per minute at rest. Having a lower than expected heartrate is a condition called bradycardia. However, he explained that based on his experience a heartrate of 47 would not be unusual in a patient who is an endurance athlete as those individuals typically have lower than the expected heartrates. He also explained that some medications may cause bradycardia. Dr. Schultz also stated that the BMI is a calculation of a patient's height versus weight used as a determination of whether a person is obese or not. He stated that a BMI of 31.31 would indicate that a patient is either obese or a body builder, but unless you know more about the patient, this BMI is a "red flag." Dr. Schulz testified that under these circumstances he would expect to see some explanation in C.A.'s medical records regarding the origin of C.A.'s low heart rate and high BMI, but no such information was contained in C.A.'s medical records. Dr. Schultz stated that the standard of care regarding the documentation of C.A.'s heartrate of 47 and BMI of 31.31 is to ask questions of C.A. regarding whether he is taking medications that could affect his heart rate, whether he has a history of endurance sports or intensive sport training, and to document that information in the patient note to explain the heartrate and BMI information. Dr. Schultz testified that respondent's failure to document that information in C.A.'s medical record was a simple departure from the standard of care of a reasonable, prudent physician under the same circumstances.

With regard to the other information in C.A.'s medical records for his June 17, 2014, visit to respondent's clinic, Dr. Schultz noted that because C.A. came into the clinic for a shoulder and ankle injury, he would expect to see information in the patient records regarding a history of present illness for the shoulder and ankle injury. Dr. Schultz stated that normally a physician will document the history of present illness, which includes how the injury happened, where it hurts, and what makes it get better or worse. However, no such information was contained in C.A.'s medical records from the clinic. Instead, the medical record for C.A. had an examination section that appeared to have information regarding a comprehensive examination you would expect to see for a periodic health screening examination with many more elements than you would expect to see for someone who came in for a shoulder and ankle injury. This indicates to Dr. Schultz that respondent asked numerous questions to C.A. to which he answered in the negative during his exam, including whether he had an irregular heart beat or heart irregularities. However, while Dr. Schultz found it surprising that such questions were asked of C.A. during his exam, Dr. Schultz did not find that this documentation for C.A.'s general examination was a departure from the standard of care.

26. With regard to C.A.'s second visit to respondent's clinic on June 20, 2014, Dr. Schultz testified that C.A. was seen that day to receive the results of the x-rays on his shoulder and ankle and according to the records C.A. was seen by respondent. Dr. Schultz noted that in this medical record there was again no history of present illness related to the shoulder or ankle injury. Also, the review of systems and examination portions of the medical record for June 20, 2014, appear to be identical to that of June 17, 2014. The

medical records also provide no information regarding the results of the ankle x-ray, but Dr. Schultz testified that he does not see that as a departure from the standard of care because the ankle x-ray results speak for themselves. Dr. Schultz noted that C.A.'s vital signs were also taken on June 20, 2014, and his heartrate was 59 beats per minute, which remains a bit low. Again, the medical records contained no information addressing the cause of the low heart rate. Dr. Schultz testified that the failure to ask information and document such information regarding the cause of the low heart rate is again a simple departure from the standard of care by respondent for the same reasons as discussed above.

27. Dr. Schultz also testified that there was no information at all in C.A.'s medical records from respondent's clinic indicating that C.A. received a TB test injection, which Dr. Schultz called a purified protein derivative (PPD) test placement. However, Dr. Schultz stated that he was instructed by the board to assume that C.A.'s statement that he received a TB test injection (or PPD test) on his arm was true and correct. Accordingly, Dr. Schultz made the assumption that C.A. did receive the TB test injection. Dr. Schultz explained that there are different ways to test a patient for exposure to TB and one of those methods has been around for decades and is called PPD, which consists of an intradermal injection on the forearm of a patient. Dr. Schulz further explained that that standard of care for providing a PPD test is to first ask the patient if they have ever had a positive TB test because if the patient has had a positive TB test in the past, you don't want to perform the TB test again because the reaction to the TB test can be much worse the second time it is given. Dr. Schultz stated that before administering a TB test, a physician must first do an assessment to determine if there is a good reason to do the TB test and also do an assessment to determine if the patient has an immunodeficiency because if so the patient may give a negative result for the TB test even though they have been exposed to TB. Additionally, if the patient has had a TB vaccination, as is common in some other countries, the patient can show a positive TB test result. Dr. Schultz also explained that if a patient has a TB test and does not go back to the physician to have the results read, there is no risk to the patient if the test is negative. However, if the test is positive there is a chance that the patient could convert from having a latent form of TB to having an active form of TB, which can be fatal. Accordingly, monitoring of the results of a TB test is important.

Dr. Schultz testified that based on his assumption that C.A. received a PPD test from respondent on June 20, 2014, respondent committed an extreme departure from the standard of care of a reasonably prudent physician under the same circumstances because there was no documentation in C.A.'s patient records regarding the administration of the PPD test, there was no documentation that respondent followed up with C.A. two or three days after the PPD test to assess the results, and there was no indication in the records to show that C.A. needed the PPD test.

TREATMENT AND DOCUMENTATION FOR PATIENT S.A.

28. With regard to the treatment of patient S.A. by respondent at her clinic, Dr. Schultz reviewed all of S.A.'s medical records from the De Anza Clinic. He noted that S.A. was first seen at respondent's clinic on September 19, 2012, and was last seen in the clinic on

September 30, 2014. S.A.'s medical records indicate that during that two year time period S.A. made 35 visits to respondent's clinic. Dr. Schultz testified that respondent uses medical records software called "e-clinical works" in her clinic, which is the same software used by Dr. Schultz in his practice. Dr. Schultz stated that e-clinical works can be customized by its users to better correspond to the user's practice. He testified that a common problem with the use of medical record software is that an error may be imputed into a patient's record and that error will be propagated into that patient's future records by default.

The reason that S.A. presented to the clinic on September 19, 2012, was documented as complaints of high blood pressure, headache, pain in hip, sour taste in the mouth with lots of phlegm, and abdominal pain. Dr. Schultz testified that on S.A.'s first visit to the clinic, she was seen by Ms. Denjalearn, who provided a comprehensive history of present illness, review of systems, physical examination on patient S.A, treatment plan with medications, and a referral to a physical therapist, which was all documented appropriately in S.A.'s medical records and electronically signed by Ms. Denjalearn. Based on the electronic signature on the medical records, Dr. Schultz stated that it is likely that Ms. Denjalearn provided the assessment and medical record information for patient S.A. on September 12, 2014, rather than respondent.

On S.A.'s next visit to respondent's clinic on September 26, 2012, the medical records are much less clear. The medical records indicate that the chief complaint of S.A. is "blood pressure check only." S.A.'s current medications are listed in this medical record, but the record provides no treatment plan or information regarding an assessment. According to Dr. Schultz, the medical record for this visit provided very little information regarding the appointment. Dr. Schultz also noted that the medical record for the September 26, 2012, appointment was electronically signed by respondent on March 13, 2015, which was years after the patient visit.

S.A.'s next visit to respondent's clinic was on September 28, 2012. The medical records for this visit show that S.A. was seen by respondent because respondent electronically signed the record for that visit. Dr. Schultz stated the medical documentation for this visit fails to provide a history of present illness, and also provides information regarding the examination of S.A. that appears to be identical to many of the other patient visit notes for visits on other dates regardless of the reason for the appointment. He stated that for this visit the assessment provided that S.A. had suffered a fall from slipping, tripping or stumbling and respondent ordered an x-ray of S.A.'s lumbar spine, as well as ordered lab blood tests for a hepatitis panel. There is no documentation in the medical records for why respondent ordered a lab blood test for a hepatitis panel for S.A.

Dr. Schultz noted that the medical records for S.A. indicate that she made visits to the clinic on October 22, 2012, and was seen by respondent. The medical records show that S.A.'s chief complaint that day was for a referral to an optometrist. The medical records also show that the review of systems and physical examination for S.A. on that date are identical to previous visits. S.A. next visited the clinic on October 31, 2012. The medical records for the October 31, 2012, visit show that the reason for the visit was for a follow–up

appointment. However, Dr. Schultz stated that the patient note shows that S.A. had a new complaint of a headache, but there was no documentation regarding any questions asked or examination regarding the headache. The information in the medical records regarding the physical exam appeared to be identical to previous visits.

Dr. Schulz noted a few other instances in S.A.'s medical records from respondent's clinic that were troubling to him. Specifically, he noted that S.A. visited respondent's clinic on September 3, 2013, complaining of right foot pain after a fall as indicated in the medical records. However, the medical records for the visit fail to provide a history of the present illness so no information was provided on when S.A. fell, the circumstances of the fall, the duration or extent of the foot pain, or description of the foot pain. The medical records provide that under the patient assessment respondent wrote that S.A. had an unspecified ankle sprain, but no other information was provided in the records about an abnormal ankle. Another instance noted by Dr. Schulz was for S.A.'s visit to respondent's clinic on July 21, 2014, where the medical records note that the reason for the appointment was mammogram results, pain in right leg, and growing mole next to right eye. However, Dr. Schulz stated that despite the growing mole next to right eye complaint, the physical examination portion of the documentation showed that the skin had "no suspicious lesions" written and under the eye portion of the physical exam nothing is noted about the mole. No other information regarding S.A.'s complaint regarding a growing mole next to her right eye is provided in the medical records for that visit. Also, Dr. Schulz noted that the medical records for S.A.'s visit to respondent's clinic on August 19, 2014, were inconsistent because the records note that the reason for S.A.'s visit was "urinating a lot" but on the same medical record under the review of systems it states that the patient "denies frequent urination," which contradicts the reason for the appointment.

29. Dr. Schwartz opined that with regard to all the medical records he reviewed for S.A. from respondent's clinic, he identified the "trend" that history of present illness for each visit is not well documented and sometimes not documented at all. Additionally, it appears to Dr. Schwartz that the physical examination information appears to be the same for every visit regardless of the reason for the visit indicating to him that default information is put into those fields from previous visits by the medical record software. He stated that there were elements of the review of systems and the physical examination for many visits made by S.A. to respondent's clinic that were consistently unnecessary and impractical given the reason for S.A.'s visit. For example, when S.A. was complaining that she needed her blood pressure medication refilled, it was not practical that respondent performed an extensive physical examination on every system of S.A.'s body particularly given the busy practice of respondent's clinic.

30. Dr. Schultz admitted that he made a mistake in his expert report regarding the medical documentation for S.A.'s visit to respondent's clinic on December 10, 2012. Specifically, the medical records indicate that S.A. was seen by Ms. Denjalearn on that visit for a referral to a dermatologist for a mole on her upper eye lid. Dr. Schultz had initially noted in his expert report that the medical records failed to give a description of the mole or lesion of which S.A. was complaining. However, Dr. Schulz testified that he made a mistake

in his expert report because the medical record did provide a detailed description of the lesion on the eye lid under the section for physical examination of the eye.

31. Dr. Schultz testified that the standard of care for a reasonable prudent physician in similar circumstances is that for each visit a patient makes to a physician for a new complaint requires documentation of the patient's complaint, and the duration, intensity, precipitating and ameliorating factors, and circumstances for that complaint. With regard to follow-up visits of a patient, the documentation for the visit may be more abbreviated. Dr. Schultz opined that respondent made a simple departure from the standard of care in her documentation of patient S.A. care as discussed above because she failed to properly document on most of the progress notes for S.A. the required information including a history of present illness, S.A.'s primary complaint, the duration, intensity, precipitating and ameliorating factors and circumstances for those complaints. Dr. Schultz further opined that respondent made a simple departure from the standard of care by using default information that was identical to previous visits for the review of systems and physical examination on most of S.A.'s progress notes. He stated that having that information in each progress notes implies that respondent provided the same extensive physical examination on the patient for each visit, when it is highly implausible that such extensive physical examination was performed on each visit.

UNAUTHORIZED DISCLOSURE OF CONFIDENTIAL PATIENT INFORMATION

32. Dr. Schulz testified and summarized in his report his opinion regarding the issue of the unauthorized disclosure of confidential patient information from one patient to another by the use of recycled paper in respondent's clinic. With regard to patient C.A., at the end of his June 20, 2014, visit to respondent's clinic he was provided documents for a referral to another physician. The back side of those documents contained confidential information of other patients, including patient G.G.'s name, date of birth, date of examination, and that patient G.G. received a positive pregnancy test, as well as patient C.F.A.'s name, date of birth and other confidential information. The documents at issue were received into evidence in this matter. With regard to patient S.A. Dr. Schultz testified that S.A.'s mammography results were printed by respondent's clinic and provided to S.A. However, the back side of those documents contained confidential patient information for patient E.T., including her full name and the results of a chest x-ray for patient E.T.

33. Dr. Schultz testified and summarized in his report that the standard of care for a reasonable prudent physician in similar circumstances is that a physician should never release any medical records or confidential information of a patient to another patient without the prior written consent of the patient to whom the records belong. Dr. Schultz described this standard of care as a regulatory standard of care rather than a clinical standard of care. Dr. Schultz noted that he understands that respondent may not have known that her staff was reusing paper in the clinic such that this information was inadvertently provided to patients. Regardless, Dr. Schultz opined that respondent's failure to ensure that this confidential patient information was not released without prior written consent from the patient is a simple departure from the standard of care. He stated that if the unauthorized

disclosure of confidential patient information was done intentionally rather than inadvertently, then he would characterize such and intentional disclosure as an extreme departure from the standard of care. However, in this case he does not believe that respondent intentionally made these disclosures, but the disclosures were unintentional. Dr. Schultz further opined that such a disclosure of confidential patient information would constitute a breach of the Health Insurance Portability & Accountability Act (HIPAA). He further stated that every time a violation of HIPAA occurs regarding the unauthorized disclosure of confidential patient information, each such violation falls below the standard of care.

Respondent's Evidence

TESTIMONY OF RICHARD A. JOHNSON, M.D.

34. Richard A. Johnson, M.D. graduated from University of Washington with a Bachelor's degree in physics in 1973. In 1977 he received his Doctor of Medicine degree from Washington University in St. Louis. He completed a residency in family medicine at UCLA in 1980. Thereafter, he joined as full-time faculty as assistant professor of family medicine, as well as director of clinical operations at UCLA School of Medicine in 1980. Dr. Johnson held those positions from 1980 to 2004 and during that time about 50 percent of his time was spent performing clinical activities in family medicine at UCLA. In 2001 he took a position with a small clinic near his home primarily treating out patients while he continued working at UCLA. In 2004 he and four other physicians purchased a clinical practice from UCLA and he now practices full-time as a family practice clinician in that clinical practice. Dr. Johnson is board certified in family medicine and has been since 1981.

35. Dr. Johnson reviewed medical records for C.A. and S.A., the investigative report from the board, Dr. Schultz's expert report, and the complete discovery provided by the board and provided an expert opinion on behalf of respondent. Dr. Johnson summarized his findings in his expert report. Dr. Johnson testified that he is familiar with the standard of care for family medicine in southern California during the 2012 and 2014 time frame.

TREATMENT AND DOCUMENTATION FOR PATIENT C.A.

36. Dr. Johnson testified that with regard to the treatment for patient C.A., he acknowledged that he did not form an opinion regarding whether or not patient C.A. was given a TB test injection by respondent. Specifically, he stated that there is no indication in C.A.'s medical records that a TB test injection was administered to C.A. and respondent "had no recollection" of giving C.A. a TB test injection. Dr. Johnson was not in the exam room at the time the TB test injection was allegedly given so he has no opinion on whether or not it was given. However, assuming that the TB test injection was administered to patient C.A. erroneously, Dr. Johnson opined that doing so would be a "negligent maneuver of little consequence" because a TB test injection is innocuous. He further clarified that he would characterize the erroneous administration of the TB test injection as "a simple act of negligence," which he defines as behavior that is outside the bounds of what a reasonably

careful physician would do in the same circumstances. Dr. Johnson testified that in order for an erroneous TB test injection to rise to the level of an extreme departure from the standard of care, the physician would have to, for example, give the injection in the patient's carotid artery for a malevolent reason. Dr. Johnson further opined that if patient was administered a TB test injection, but the physician did not read the results of the TB test injection within the 48 or 72 hour time frame, failure to do so would be a simple departure from the standard of care. Dr. Johnson stated that the patient must have a legitimate evaluation of the test results from a TB test injection. He further stated that it is not a departure from the standard of care to fail to record that a TB test injection was given to a patient, but it would be a simple departure from the standard of care if the physician failed to record the results of the TB test injection in the patient's records.

Dr. Johnson further explained that TB is a complicated illness, and most of people who have TB have a latent form of it where their immune system "walls off" the TB and keeps it in check. The individuals with latent TB are the group of individuals from which full-fledged TB arises. The TB test injection is the injection of about 1/10 of a milliliter of a PPD under the skin of a patient typically given in the palmer part of the forearm. The test is used to check for a person's immunity to TB and if the patient has a reaction to the test, which is generally in the form of a small granuloma developing at the site of injection, it signifies that your body has a memory or immunity to TB because it has been previously exposed to TB. The patient's reaction to the test is typically measured in 48 to 72 hours after the injection. If the patient has a reaction, the size and firmness of the red bump at the site of injection is indicative of whether the patient has a latent form of TB. The larger the bump, the more highly predictive that the patient has latent TB. Dr. Johnson stated that a TB test injection is a benign test, unless you were to inject the contents into an artery.

37. With regard to the documentation of the treatment of patient C.A. by respondent at the clinic, Dr. Johnson opined that respondent's medical records for patient C.A. were "quite well done." He stated that there are different levels of documentation present in the community and medical record documentation spans a wide spectrum of what a reasonably careful physician would do. Dr. Johnson testified that some physicians will only have handwritten notes with only a little information provided and other physicians will have pages and pages of records that "pulls forward information" for a simple office visit. Dr. Johnson stated that every medical note does not need to contain a history of present illness and many reasonable practitioners do not have a history of present illness in their medical records. Dr. Johnson does not use electronic medical records in his practice at all, despite his testimony that about 80 percent of physicians in southern California do use electronic records. He stated that he does not use electronic medical records because he has seen no evidence that they improve patient care and the software is expensive. Dr. Johnson believes that electronic medical records tend to make physicians slaves to the software system instead of attentive to the needs of the patient. Dr. Johnson stated that one particular problem with electronic medical records is that the software tends to "repopulate" the records with information from previous visits causing rampant problems in the medical profession. Dr. Johnson testified that the reason a medical record is kept from a physician's standpoint is so that another provider can pick up the records and be able to continue treatment of the

patient based on the history provided in the medical records. Dr. Johnson stated that he has absolutely no concern that another practitioner could pick up the medical records of C.A. and continue treatment successfully based upon the information it contained. Dr. Johnson stated that the documentation for the treatment of patient C.A. for both June 17, 2014, and June 20, 2014, were adequate and within the standard of care.

38. With regard to patient C.A.'s heart rate of 47 and 59, Dr. Johnson stated that no further documentation was necessary to explain C.A.'s heart rate because C.A. is a young male in good condition and for him that heart rate is normal and good. Dr. Johnson further stated that he did not believe that there was any reason to document the fact that C.A. was a professional athlete to explain the heart rate. He also stated that a heart rate of 47 would be normal for adolescent or young male regardless of their level of physical fitness and a prudent reasonable physician would know that. Furthermore, with regard to C.A.'s BMI measurement of 31.31, Dr. Johnson explained that the BMI I a measure of body fat, but the measurement is not very precise. For example, an old woman with osteoporosis could have a height that is much shorter than her actual height, or you could have an athlete with big muscles and in each case you may get a BMI that would indicate obesity when in reality the patient was not obese. Dr. Johnson opined that C.A.'s BMI measurement is "of no issue in this case."

39. Dr. Johnson further opined that with regard to C.A.'s medical records related to his shoulder pain and ankle pain for the last four months, a family practitioner will likely inquire about what the pain has been like over the past four months, if the level of pain changes, or the range of motion in the shoulder or ankle. However, he specifically stated that the family practitioner is not required to document that information in the patient's medical records. He further stated that a family practitioner may ask the patient about what medications they are taking, but that information is not required to be documented in the patient's medical records.

TREATMENT AND DOCUMENTATION FOR PATIENT S.A.

40. With regard to the documentation for the treatment of patient S.A., Dr. Johnson testified that his review of patient S.A.'s medical records from respondent's clinic shows that S.A. had a lot of medical problems and was given "a ton" of referrals and follow-up treatment. Dr. Johnson stated that patient S.A. received "good care" from respondent. He testified that all of the patient notes in S.A.'s medical records from respondent's clinic were appropriate for the situation at hand and he characterized the patient notes as "average if not better than average." Dr. Johnson stated that the medical records and documentation of S.A.'s care by respondent's clinic were fine and adequate for another family practitioner to pick up the records and continue care.

41. Notably, when asked whether he believed that the adequacy of documentation in a medical record is a standard of care issue at all, Dr. Johnson stated "not unless you are at an extreme boundary of putting fraudulent information in the medical record for an intentional purpose."

42. Dr. Johnson further opined that the fact that the information under review of systems in S.A.'s medical records may have been repopulated by the software by an earlier visit does not make the progress notes inaccurate. Dr. Johnson stated that it is a common problem today in the practice of family medicine and acceptable for a family practitioner in southern California. He stated that after reviewing the medical records of S.A. for the two years she was treated at respondent's clinic, he did note that the review of systems information was the same for most of her progress notes for each visit. While Dr. Johnson did not believe that all of those questions were asked of S.A. during each visit, he does not believe that it was below the standard of care for that information to be repopulated on each visit because family physicians "know that is what happens." Additionally, he stated that he knows that S.A. was examined on each visit, but "the details of which I don't know."

UNAUTHORIZED DISCLOSURE OF CONFIDENTIAL PATIENT INFORMATION

43. Dr. Johnson testified that he understood that there was a disclosure of confidential medical records from one patient to another patient without the required authorization because respondent's clinic had a practice of recycling paper that had confidential information on it. He stated that he believes based on the information he reviewed that respondent had no knowledge that the paper with confidential information on it was being re-used on the other side to give to other patients. However, Dr. Johnson opined that such disclosures were "a regulatory issue" and not a "standard of care issue." He characterized the unauthorized disclosure of confidential patient information in this matter as "an administrative error of significant proportion." Dr. Johnson opined that standard of care issues involve patient care only and not the protection of patient information, which he characterized as regulatory only. Dr. Johnson testified that while he agrees that a physician has a duty to maintain the confidentiality of patient medical records, such a duty is equivalent to the duty to make sure that the floor is not too slippery or that the bathrooms meet the requirements of the Americans with Disabilities Act (ADA).

44. Accordingly, Dr. Johnson opined that respondent did not violate the standard of care of a reasonably prudent physician in southern California for her inadvertent and unauthorized disclosure of confidential medical information from one patient to another.

TESTIMONY OF WARREN ALLEN HEFFRON, M.D.

45. Warren Allen Heffron, M.D. graduated medical school at the University of Missouri in 1962. He completed an internship in internal medicine at University of California, Irvine and thereafter was drafted into the military and spent three years on public service as a physician. He finished his internal medicine residency in 1971 at the University of New Mexico. Thereafter, Dr. Heffron became part of the faculty of the University of New Mexico (UNM) where he started a family medicine department. Dr. Heffron was the chairman of the department of family medicine at UNM for 12 years. He has practiced internal medicine for many years, as well as taught medical students. Dr. Heffron was board certified in internal medicine for 42 years until he retired from clinical practice in December

2016. He continues to work at UNM and is currently on the faculty of UNM and has resided in Albuquerque, New Mexico for 49 years. He has held the position of president of the American Board of Family Medicine, as well as the position of vice president of the American Academy of Family Physicians. He has also held the position of president of the New Mexico Medical Society.

46. Dr. Heffron has known respondent for nine years since they met in 2008. He first met respondent while he was leading a medical study tour of Egypt in 2008 and respondent went on the tour. Dr. Heffron spent a couple of weeks with respondent in Egypt interviewing and interacting with physicians. After this 2008 tour, Dr. Heffron met respondent again two years later while working in a mission hospital in upper Egypt. Respondent was there in Egypt and helped by teaching some of the residents. Dr. Heffron was able to observe her activities and teaching during that time. He described her as a fine teacher. Dr. Heffron met respondent again a couple of years later in Rwanda while visiting a medical school there where respondent was providing clinical work and teaching for an international medical charity. Dr. Heffron observed that respondent was a good clinician and teacher in Rwanda, as well. Dr. Heffron has maintained contact with respondent over the years and is still involved in international medical mission trips. Dr. Heffron described respondent as a unique lady because she was providing care in a Christian mission hospital in the Muslim country of Egypt. He stated that respondent is from Egypt and wanted to give back to her roots and train physicians. He found her to be highly motivated and inspiring. Dr. Heffron further stated that respondent's ethics and honesty are superb, and that she is forthright and medically knowledgeable. He unhesitatingly endorsed respondent as a physician and professional.

TESTIMONY OF EUNICE FERNANDEZ

47. Eunice Fernandez currently works as a full-time medical assistant for respondent in her De Anza clinic. Ms. Fernandez graduated Calexico High School in 2007 and thereafter attended Imperial Valley College where she completed a two year medical assistant program. She stated that the medical assistant program consists of two years of training where the first year provides training in "front office" work and the second year provides training in the "back office" work. Ms. Fernandez first began working for respondent in the De Anza clinic as a receptionist in February 2012 after she had completed her first year of training at Imperial Valley College and while still completing her second year. After completing her second year Ms. Fernandez became a certified medical assistant. After working for respondent for a few months as a receptionist, Ms. Fernandez was promoted to work in billing and referrals where she worked for one year. Thereafter, in 2014 Ms. Fernandez began working full-time for respondent as a medical assistant in the "back office" in the De Anza clinic.

48. Ms. Fernandez testified regarding the layout of the De Anza clinic and stated that the clinic has three exam rooms, a hallway, and a lobby/waiting room. She stated that when a patient arrives at the clinic they first check-in with the receptionist, who inputs the information into a computer. The computer is networked to other computers in the clinic

such that Ms. Fernandez and the "back office" staff can see on the computer that the patient has arrived and how long they have been waiting. Ms. Fernandez stated that the De Anza clinic has a good work flow and can get very busy and on a busy day patients can be expected to wait to be seen by a physician for an hour or an hour and a half. According to Ms. Fernandez, after seeing that the patient has arrived on the computer she will go to the waiting room to call the patient and bring them into an exam room. She stated that patients are brought back to the exam room roughly in their order of arrival at the clinic or at their scheduled appointment time. After brining the patient into the exam room, Ms. Fernandez asks the patient his or her chief complaint, takes vital signs, and then takes the patient back to the waiting room to wait to be seen by the physician. Ms. Fernandez enters the vital signs and chief complaint into the patient's medical records. When the physician is ready to see the patient Ms. Fernandez will get the patient from the waiting area and take them to the exam room for the physician.

49. Ms. Fernandez recalled patient C.A.'s first visit to the De Anza clinic on June 17, 2014. She stated she remembered C.A. because she had attended high school with him. She stated that on June 17, 2014, when C.A. came to the clinic she called his name from the waiting room and took him back to ask him his chief complaint and take his vital signs. Ms. Fernandez stated that she input into C.A.'s medical records for the June 17, 2014, visit that his chief complaint was an injury to the right shoulder from wrestling and left ankle pain. She also inputted his vital signs including his heart rate into the medical records. Ms. Fernandez thereafter took C.A. back to the waiting room until respondent was ready to see him. Ms. Fernandez thereafter brought C.A. back to an exam room to see respondent and Ms. Fernandez did not stay in the exam room for the examination of C.A. Ms. Fernandez stated that she had no other interaction with C.A. on June 17, 2014, and that his visit that day was typical and did not stand out as unusual.

50. Ms. Fernandez recalled C.A.'s visit to the clinic on June 20, 2014. She stated that on that day C.A. came to the clinic and Ms. Fernandez brought him back to the exam room to take his vital signs and ask why he was in the clinic that day. Ms. Fernandez input into C.A.'s medical records through the computer that the reason for his visit on June 20, 2014, was to obtain the x-ray results from his shoulder and ankle x-ray. She also inputted his vital signs including his heart rate into his medical records. Thereafter, Ms. Fernandez took C.A. back to the waiting room to wait for respondent. When it was time, Ms. Fernandez brought C.A. back to the exam room where respondent was waiting for him. Ms. Fernandez then left the exam room and did not stay for the examination of C.A. Ms. Fernandez stated that she never went into the exam room with C.A. where respondent was waiting. She also stated that she never brought a paper bag into that exam room to give to respondent. After she left the exam room where she left C.A. with respondent, Ms. Fernandez continued to tend to other patients. While she was with another patient, Ms. Fernandez heard respondent call her name with a tone of voice that seemed urgent. Ms. Fernandez stated that she rushed to the exam room where respondent was located with C.A., and by the time Ms. Fernandez arrived at that exam room C.A. had already exited the room and was walking toward the reception area. Ms. Fernandez stated that C.A. turned and looked at Ms. Fernandez and said "she gave me a TB test." Ms. Fernandez testified that when he said this she looked at

respondent's arm where a TB test would be given to see if she could see anything. Ms. Fernandez stated that she did not see anything on C.A.'s arm. Ms. Fernandez stated that she could see C.A.'s arm because he was wearing a short sleeve t-shirt, but she did not recall the color of the t-shirt. Ms. Fernandez stated that C.A. proceeded to walk toward the reception area and respondent followed him. Ms. Fernandez then went back to tend to her other patient. Ms. Fernandez described C.A.'s demeanor during this incident as "upset" and that he was loud. She stated that she could hear C.A. while she was tending to the other patient. She stated that she could hear C.A. talking to respondent in a loud voice but could not hear what they were saying. Ms. Fernandez stated that C.A. spoke English to her at all times he was in the clinic and never spoke Spanish to her.

51. Ms. Fernandez described the procedure followed at the clinic for Immigration and Naturalization Service (INS) patient examinations. She stated that INS patients are required to have certain immunizations and a TB test. Ms. Fernandez stated that for those cases she will place the immunization vials and TB test vials on the counter top in the exam room or give them directly to respondent prior to bringing the patient into the exam room. She stated that she does not bring in a syringe into the room because the syringes are already stored in the second drawer of the exam room beneath the laptop computer. She stated that respondent will obtain the syringes, needles and alcohol wipe from the drawer herself for those vaccinations and TB test injections.

TESTIMONY OF LAWRENCE LEWIS

52. Lawrence Lewis has worked in the health care industry since 1980. He is currently the Chief Executive Officer (CEO) of Pioneer Regional Hospital and has held that position since 2012. He first met respondent soon after taking the CEO position at Pioneer Regional Hospital and has had a good working business relationship with respondent for the past five years. Mr. Lewis testified that Pioneer Regional Hospital leases property from respondent in order to operate a clinic. He stated that respondent owns a significant property that used to be a hospital. Respondent took over the ownership of the building that used to be a hospital after the hospital closed. Mr. Lewis testified that Pioneer Regional Hospital currently leases a wing of that hospital owned by respondent to operate a clinic with four or five providers. The remainder of the hospital is operated by respondent for her clinic and a portion of the building is vacant. Mr. Lewis described respondent as a very good landlord and stated that Pioneer Regional Hospital currently has a long-term lease with respondent for a term of 30 years.

53. Mr. Lewis testified that respondent is a member of the medical staff at Pioneer Regional Hospital and has a longstanding good reputation. He stated that her practice serves an underserved rural community with extremely poor patients. Mr. Lewis testified that the Calexico area has been statistically evaluated to be a "grossly underserved" area for medical providers to patients. He stated that there are very few physicians who are willing to practice in such a grossly underserved area with very poor patients. He stated that respondent is "big hearted" and serves her community very well.

54. Mr. Lewis has observed respondent's clinic and the patients it serves. He stated that he comes to the clinic to discuss the property and improvements. Mr. Lewis described respondent's clinic as "very busy" and usually packed with low income patients. He stated that he visits her clinic about eight to ten times per year and each time he has been to her clinic it is extremely busy.

55. Mr. Lewis testified that he is aware that an accusation had been filed against respondent because he received a report from one of his staff members that a patient who had been referred to the clinic for Pioneer Regional Hospital from respondent's clinic arrived with his or her medical records. Inside those medical records were other medical records from another patient that appeared to be erroneously provided. Mr. Lewis stated that this information was the extent of his knowledge about the accusation filed against respondent.

TESTIMONY OF JOYCELYN LIGHTFOOT

56. Joycelyn Lightfoot worked for 34 years as a nurse until her retirement in 2011. She first became a nurse's aide in 1976. In 1980 she became a licensed vocational nurse, and in 1984 she became a registered nurse. She worked at El Centro Regional Hospital for 34 years as a nurse. Ms. Lightfoot first met respondent when respondent would come to her floor at the El Centro Regional Hospital to see her patients. About eight years before she retired in 2011, Ms. Lightfoot became respondent's patient and has remained her patient to this day. Ms. Lightfoot has observed respondent as a physician working with her patients at the hospital, as well as being a patient of respondent.

57. Ms. Lightfoot testified that respondent is well-respected by patients and her peers. Ms. Lightfoot stated that over many years she has only heard positive remarks about respondent in the medical community and trusts the knowledge and judgment of respondent. Ms. Lightfoot's relationship with respondent is professional only and she does not interact with respondent socially.

58. Ms. Lightfoot also stated that she is aware that an accusation is pending against respondent's license. She stated that she is aware of the accusation because she discussed it with respondent about six months ago. She understands the accusation involves an accusation by a patient that "he received an injection when he did not."

RESPONDENT'S TESTIMONY

59. Respondent enjoys working with her patients and has been treating some of her patients for over 20 years. She considers her patients as an extension of her family. Respondent testified that her clinic has a routine practice regarding the intake of patients as they arrive at the clinic. Specifically, her clinic treats patients who have made an appointment for their visit, as well as patients who simply walk into the clinic without an appointment. When a patient arrives at the clinic they first check-in with the receptionist. The receptionist gives the patient a package of documents which includes a questionnaire regarding the patient's health and health history, an agreement regarding HIPAA, and

document requesting insurance information. The patient is asked to fill out the requested information on the documents while they wait. Respondent stated that the staff is supposed to scan into the medical records the medical questionnaire filled out by the patient, but sometimes the staff forgets to do this. After the questionnaire is scanned into the medical record, the hard copy of the questionnaire is shredded. Thereafter, the patient is called by a staff member and taken into an exam room so that the staff member can take the patient's vital signs and ask the patient the reason for the visit. The staff member then takes the patient back to the waiting room to wait to be seen by a physician when there is availability. Respondent stated that there is a computer system in her clinic that is at the receptionist's desk and in the back office. When a patient arrives that information is entered into the computer by the receptionist and can be seen on the other computer terminals throughout the clinic. After the patient's vital signs have been taken, the staff member enters that information in the computer and it can be seen on the other computer terminals.

60. Respondent explained that she has three exam rooms in her clinic and the second exam room is larger than the others and typically used for families or persons with wheelchairs. The third exam room is typically only used for patients to wait for results and not used for examinations. Respondent stated that none of her exam rooms have desks.

Treatment and Documentation for Patient C.A.

61. Respondent testified that she recalled both of the visits from C.A. to her clinic in 2014. On his first visit on June 17, 2014, C.A. appeared agitated from his wait in the waiting room. Respondent stated that C.A. told her that he was a wrestler in Mexico and she attempted to make small talk with him about her knowledge of wrestling in Mexico based upon her treatment of a champion wrestler in the past. Respondent observed that C.A. was "kind of rough" and did not want to chat. She then performed a physical examination of C.A. and asked him to move his shoulder and ankle so she could evaluate his range of motion and the source of the pain. She recalled that C.A. was able to extend his shoulder all the way around and she was surprised that his shoulder had been tender for a number of months. Respondent informed C.A. that she needed to send him for x-rays to determine the source of the pain in the shoulder and ankle. She informed C.A. that she may need to send him to physical therapy because the pain had been present for a number of months. Respondent stated that she spent about 15 minutes with C.A. during his June 17, 2014, visit to her clinic. Respondent testified that during this June 17, 2014, visit by C.A. she asked C.A. the majority of the questions on the review of system's portion of her e-clinical software and some of the information in that portion of the medical records came from the questionnaire C.A. answered.

62. On June 20, 2014, during C.A.'s second visit to respondent's clinic, respondent had multiple patients to see that day and C.A. was on the schedule to be seen that day at 8:50 a.m. Additionally, respondent had an INS patient scheduled to be seen that day at 8:10 a.m. She explained that INS patients will receive a tetanus shot, as well as a TB test injection. Typically, when she sees an INS patient, the staff will set out the vial for the tetanus shot and TB test injection on the counter of the exam room where the INS patient is

to be seen. Respondent stated that on June 20, 2014, she was sitting in a swivel chair in the exam room typing on her laptop. She noted that on the counter of the exam room behind the laptop were the vials for the tetanus shot and TB test. Accordingly, she assumed that the patient entering the exam room, who was C.A., was her INS patient. When C.A. entered the exam room, respondent started asking him questions that she would typically ask an INS patient, such as if they had a family history of TB or any allergies related to a TB test injection. Respondent was asking these questions of C.A. while she was starting to load the tetanus shot into a syringe from the vial. She had taken the syringe and alcohol wipe from the drawer under the laptop. Respondent stated that she wiped C.A.'s arm with the alcohol pad in preparation for the injection. According to respondent, C.A. looked at respondent strangely and asked her, "What are you doing?" Respondent told C.A. "I am giving you a tetanus shot and a TB test." C.A. then informed respondent that he was not there for a shot. Respondent then stopped what she was doing and asked C.A. why he was in the clinic that day, and C.A. told her to get his x-ray results and for a letter for his mother. Respondent testified that she never gave C.A. any injection for any purpose on June 20, 2014.

Respondent asked C.A. the name of his mother and informed him that his mother would have to come to the clinic for the letter he was requesting and that she could not give him any information regarding the care of his mother. Respondent testified that C.A. seemed angry and she did not know why. Respondent looked up C.A.'s x-ray results on the computer and asked C.A. if his shoulder and ankle were still bothering him. According to respondent, C.A. informed her that his ankle was better but his shoulder still hurts. Respondent stated that C.A. was moving his shoulder well. She told C.A. that his x-ray results were normal and he had two options, either she could send him to a physical therapist or to an orthopedic surgeon. Respondent inquired about C.A.'s insurance and after learning the answer she informed C.A. that there is only one orthopedic surgeon in the area that took his form of insurance. Respondent began creating the referral to the orthopedic surgeon. She reiterated that C.A. seemed upset because she would not provide him the information he requested regarding his mother.

According to respondent, C.A. then stood up in the exam room and exclaimed "you gave me a shot." Respondent stated that she was stunned. She said that C.A. made her doubt herself for a moment, so she looked at the vials and they were untouched. Respondent stated that C.A. then walked to the door and out to the hallway and Ms. Fernandez was there. C.A. again stated in a loud tone of voice "she gave me a shot," and "she gave me a TB shot." Respondent stated that C.A. seemed angry and she was concerned that he would hurt a member of her staff. Respondent stated that at that time she had not even loaded the TB test injection into the syringe and had only loaded the tetanus shot into the syringe. Respondent told C.A. that she did not give him a shot and he knew that, and if he did not calm down she would call the police. Respondent stated that she took her phone and dialed 9, but before she could dial the 11, C.A. walked out of the clinic. Respondent stated that she never saw C.A. again. Respondent estimated that it took seconds for C.A. to exit the exam room, and it took him about two minutes to get from the exam room to the entrance of the clinic when he left. Respondent stated that she spent about 15 minutes with C.A. during his visit to her clinic on June 20, 2014.

63. Respondent testified that later on June 20, 2014, she did give the tetanus shot and the TB test injection to the correct INS patient. She documented this information in the medical records for the INS patient. Respondent stated that she has a limited number of vials of the TB test in her clinic and she had only the number of vials in her clinic that day necessary to cover the patients requiring a TB test injection on June 20, 2014. She stated that she was expecting another shipment of the TB test injections, but was very careful regarding their use because she only had enough for exactly the number of patients scheduled.

64. With regard to the documentation of her care of C.A., respondent stated that C.A. had filled out a medical questionnaire asking about his health and medical history and she looked at it in the exam room when C.A. was with her on June 17, 2014. However, she stated that that questionnaire was supposed to be scanned into C.A.'s medical record but was not. She did not know what happened to that medical questionnaire for C.A. Respondent recalled asking questions of C.A. based on the answers he put in the questionnaire, but she did not ask him "in detail" about the answers he put on the questionnaire. Although respondent did not know what happened to the questionnaire completed by C.A., she did have a copy of the same questionnaire used by S.A. and stated that the questionnaire is the same for all of her patients, other than the language used as some patients receive the Spanish version and others the English. Respondent admitted that the questionnaire form does not include the same questions as those shown in the review of systems on the e-clinical software used for her patient records.

65. Respondent testified that when a patient first visits her clinic, she completes the information shown on the review of systems portion of the e-clinical software patient records. She stated that she does not ask those questions of the patient again on their subsequent visits, but the software will automatically repopulate that information into the progress notes for each visit of the patient even though she does not ask the patient those questions. Respondent stated that this is a problem with the software and she has contacted the software company regarding the problem. She stated that the software company created a "ticket" for her when she contacted them and they have been out to her office for training. According to respondent, in October 2014 the company sent trainers to her office and as a result of the training, she decided to upgrade her software so as to get more templates. She received that upgrade in October 2014 and as a result her patient documentation has improved.

66. Respondent stated that she understands that the purpose of the medical record is to maintain continuity of care if another caregiver were to pick up the medical records for a patient. She stated that the medical records for C.A. are adequate and accurate for that purpose. With regard to the heart rate of C.A., she stated that the low heart rate of 47 can be potentially dangerous if the patient is symptomatic. However, C.A. is a young male and athletic so such a heart rate would be normal. When asked if it was necessary to document in the patient records that C.A. was physically fit and athletic, respondent stated that such documentation was not necessary. She noted however that the record states that C.A. sustained his shoulder injury while wrestling and this information alone should be sufficient

documentation of his physical fitness. She also stated that C.A. was sent to a specialist on a referral and when a patient is sent to a specialist there is no further documentation necessary other than the fact that the patient was sent to a specialist.

Treatment and Documentation for Patient S.A.

67. With regard to the treatment and documentation of care for patient S.A., respondent testified that S.A. was her patient for about two years and during that time had approximately 35 visits to her clinic. Respondent reviewed all of S.A.'s medical records from the clinic and noted that a majority of the visits were for treatment of hypertension. Respondent stated that for each of those visits by S.A. to her clinic, respondent performed a physical examination of S.A. but admitted that although the information in the review of systems for each progress note was the same and present for each visit, respondent did not ask those questions of S.A. for each visit. Respondent again noted that this was a repopulation of information done by the e-clinical software. Respondent stated that she enters all the information into a progress note for a patient visit on the same day that the patient is in her clinic. She stated that she never changes a progress note after the day of its entry.

68. Respondent stated that her review of all the patient medical records for S.A. showed that her documentation was adequate and complete and allowed a subsequent medical provider to easily continue the care for S.A.

Unauthorized Disclosure of Confidential Patient Information

69. Respondent testified that she first learned that her staff was re-using paper which contained confidential patient information sometime in April 2015 when the board subpoenaed records from her clinic. She stated that upon receiving the subpoena she learned that her staff was re-using the paper and was providing unauthorized confidential patient information to other patients. Respondent stated that upon learning this, she immediately contacted her malpractice insurance and her attorney for guidance. Thereafter, she had her attorney draft an agreement for each of her staff members to sign. The agreement lays out the obligations of the staff to keep patient information confidential. Additionally, respondent also set up a HIPAA training session for her staff to educate them on the importance of HIPAA issues. Respondent stated that she has not had any problems with HIPAA violations since she took these steps.

70. Respondent testified that with regard to the patients whose confidential medical records were inadvertently given to other patients on the re-used paper, respondent informed each of the patients of which she became aware and apologized to them. Respondent stated that this mistake will never be repeated.

Mitigation and Rehabilitation Evidence

71. In addition to having her staff complete training regarding HIPAA requirements, respondent completed a two day course from UCSD School of Medicine Physician Assessment and Clinical Education Program (PACE) on April 27-28, 2017, for Medical Record Keeping and obtained 17 hours of credits. Respondent stated that the course was beneficial to her. She was required to submit patient records for review to the UCSD PACE program prior to the start of the program. Respondent stated that she sent the medical records alleged in the accusation as being insufficient. According to respondent, the reviewers from the PACE program told her that those records were very good. Respondent stated that she learned some additional techniques regarding documenting her patient visits. Respondent acknowledged that she needs to do more work with her e-clinical software to become more proficient with it, which she intends to do.

72. Respondent is also a Medi-Cal managed care provider. In order to be a Medi-Cal managed care provider she must meet strict standards for her facility and patient records. In order to ensure compliance, the California Department of Health randomly audits her facility and medical records approximately every three years. She stated that the medical records are typically reviewed by a registered nurse or a nurse practitioner. Respondent had a Medi-Cal Record Review from the California Department of Health Services, Medi-Cal Managed Care Division on January 22, 2014. Respondent stated that the result of this record review showed that her medical records were very good as shown by the high resulting scores from the audit. The audit documents were received into evidence and supported her testimony.

73. Respondent submitted six reference letters from various individuals in her support. One letter was from Mark R. Lynn, CPA, President and CEO of Healthcare Business Specialists. He wrote that he has known respondent for 20 years as a consultant and rural health advocate. Respondent testified that Mr. Lynn is a Medi-Care auditor and has his own business surveying hospitals. Mr. Lynn wrote that respondent implemented a quality improvement program in her clinic, and her medical records have been reviewed many times and demonstrate her high standards. He further wrote that respondent provides high quality medical care for her patients in an area that has few medical providers.

The second letter was written by May Denjalearn, M.D. Dr. Denjalearn received her nurse practitioner degree in 2010 and worked for respondent as a nurse practitioner from March 2012 to Dec. 2013. Dr. Denjalearn recently finished medical school. She praised respondent's professionalism, work ethic, and high quality care for her patients.

The third letter was from Karen Orozco, a nurse practitioner who worked closely with respondent from 2011 to 2012. Ms. Orozco praised respondent's professionalism and quality of care for her patients, particularly in a rural environment.

The fourth letter was from Leslie Mukau, M.D. the medical director of emergency medicine at El Centro Medical Center and assistant clinical professor of emergency medicine at UCSD Health Services. Dr. Mukau wrote that he has known respondent since 1995. He wrote that he knows respondent primarily from his work at El Centro Regional Medical

Center and from her work as a clinical instructor at UCSD. Dr. Mukau praised respondent's professionalism, great reputation as a clinician, and quality of care provided to patients.

The fifth letter was from Travis Calvin, M.D. He wrote that he has known respondent since she began her practice in Calexico. Dr. Calvin wrote that he has heard of no complaints of her patient care and that respondent has a great reputation in the community and as a clinician. He further wrote that she is a valued member of Imperial County Medical Society.

The final letter was from Jose Rocamora, M.D. He wrote that he has known respondent for many years. Dr. Rocamora praised respondent's compassion towards her patients, her dedication to her work, her professionalism and her quality of care.

The Parties' Recommendations

74. Complainant argued that this case involves simple departures from the standard of care with regard to the medical record documentation and the unauthorized disclosure of confidential medical information, but the case involved an extreme departure from the standard of care with regard to the administration of the TB test injection to C.A. when it was not indicated and without reading the results of the TB test. Complainant emphasized that respondent simply lied about the fact that she gave C.A. this TB test injection because the overwhelming evidence shows that he received the injection. This raises serious issues with regard to respondent's trustworthiness. Complaint argued that a probationary term is appropriate in this case, but did not provide a recommendation on which terms would be appropriate.

75. Respondent argued that the charges related to the performance of the TB test injection on patient C.A. should be dismissed because respondent testified that she did not give C.A. the injection and respondent's credibility is impeccable. Furthermore, respondent argued that with regard to the unauthorized disclosure of confidential medical information, this is simply a regulatory issue and not a standard of care issue, and that no discipline be ordered as a result. With regard to the medical record documentation issue, respondent argued that while respondent had issues with her medical record software as many physicians do, her record keeping was within the standard of care and no discipline should be ordered. Respondent argued that no discipline should result from this case, but that if any discipline is ordered, a probationary term is unjust and unwarranted and a public reprimand would be more appropriate.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant bears the burden of proof of establishing that the charges in the accusation and petition to revoke probation are true.

2. With respect to the accusation portion of the pleadings, the standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The obligation to establish charges by clear and convincing evidence is a heavy burden. It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

The Physician-Patient Relationship

3. There is no other profession in which one passes so completely within the power and control of another as does the practice of medicine. The physician-patient relationship is built on trust. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 578-579.)

4. Because the main purpose of license discipline is to protect the public, patient harm is not required before the board can impose discipline. It is far more desirable to impose discipline on a physician before there is patient harm than after harm has occurred. Prevention of future harm is part of public protection. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772-773.)

Applicable Disciplinary Statutes

5. Under Business and Professions Code section 2234, the board shall take action against a licensee charged with unprofessional conduct. Grounds for unprofessional conduct include, but are not limited to, gross negligence (subdivision (b)) and repeated negligent acts (subdivision (c).)

6. It is also unprofessional conduct for a physician and surgeon to fail to maintain adequate and accurate records relating to the provision of services to his or her patients. (Bus. & Prof. Code, § 2266.)

The Standard of Care, Gross Negligence, and Ordinary Negligence

7. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

8. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v.*

Board of Medical Quality Assurance (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

9. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.)

10. Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

11. A physician's failure to complete or maintain patient records can constitute gross or simple negligence, depending on the circumstances. (*Kearl v. Board of Medical Quality Assurance, supra, at pp.* 1054.)

The Proper Measure of Discipline

12. The primary purpose of disciplinary action is to protect the public. (Bus. & Prof. Code, § 2229, subd. (a).) The Medical Practice Act emphasizes that the board should "seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies." (Bus. & Prof. Code, § 2229, subd. (c).) However, "[w]here rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

13. The issue of whether respondent erroneously performed a TB test injection on patient C.A. is one of credibility of the witnesses. Four credible witnesses testified that after his visit with respondent, C.A. had a red bump on the palm facing portion of his forearm in a location where a TB test injection would be given. Respondent and her employee, Ms. Fernandez, provided testimony to refute the assertion that the TB test injection was given to C.A.

During his testimony C.A. answered questions directly and without hesitation or exaggeration. C.A.'s demeanor and manner while testifying were consistent with telling the truth. The character and quality of C.A.'s testimony was more compelling that that provided by respondent. C.A. recalled and testified about a great number of details, and he had no interest in the outcome of this accusation. C.A.'s testimony that respondent erroneously gave him the TB test injection was supported by the testimony of S.A., of his girlfriend Sophia Camacho, and by his girlfriend's sister Paloma Camacho, who is also a nurse practitioner and is familiar with the TB test administration and results. Each of those individuals testified that they saw the red bump on C.A.'s palm facing portion of his forearm where a TB test injection would be given. Paloma Camacho testified that the red bump she saw on C.A.'s forearm was consistent with a positive result for a TB test. The testimony of each of those individuals was forthright, direct and credible. As it is well established, the testimony of one

credible witness may constitute substantial evidence. (*In re Frederick G.* (1979) 96 Cal.App.3d 353, 365 cert. den. 100 S.Ct. 2150; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052-1053.) In this case C.A. was a credible witness testifying that respondent gave him the TB test injection, and three credible witnesses supported that testimony by stating that they saw the red bump on his forearm where the TB test injection would be given.

By comparison, respondent, and her employee Ms. Fernandez, have a stake in the outcome of this accusation because any discipline placed on respondent's license will affect the operation of the clinic that employs them. Both Ms. Hernandez and respondent testified that on June 20, 2014, C.A. was upset and exited the exam room at respondent's clinic stating in a loud tone of voice that respondent gave him a shot. Respondent testified that C.A. was so upset that she started to dial 911 because she was concerned C.A. would injure her staff. Respondent also testified that C.A. exited the exam room in a matter of seconds and exited the clinic in about two minutes during a time he was loud and obviously upset. Despite these circumstances, Ms. Fernandez testified that during the time C.A. was in the hallway and after he exited the exam room, she was able to clearly see the palm facing portion of his forearm, and make a determination that no TB test had been given to him. Ms. Hernandez's testimony regarding this observation is simply not believable under those circumstances.

14. Dr. Schultz's testimony that respondent's administration of the TB test injection to C.A. when it was not indicated and thereafter failing to read the results of that TB test injection or to document it in C.A.'s medical records constitutes an extreme departure from the standard of care of a reasonably prudent family physician in similar circumstances was credible. By comparison Dr. Johnson testified that respondent's administration of the TB test injection to C.A. when it was not indicated and thereafter failing to read the results of that TB test injection or to document it in C.A.'s medical records would only constitute a simple departure from the standard of care of a reasonably prudent physician under the same or similar circumstances. Dr. Johnson further stated that the only way an erroneous TB test injection could constitute an extreme departure from the standard of care would be if, for example, the physician injected it into the patient's carotid artery for a malevolent reason. Dr. Johnson's testimony in this regard was less credible than that of Dr. Schultz. While Dr. Schultz and Dr. Johnson are both highly credible experts whose education, training, experience and medical knowledge are superb, Dr. Shultz's opinions with regard to this issue are more credible than those of Dr. Johnson because Dr. Johnson failed to take into account the totality of the circumstances that respondent not only erroneously gave C.A. the TB test injection when it was not indicated, but failed to read the results, and failed to record any of that information in C.A.'s medical record. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

15. With regard to the documentation of medical records for patient C.A., Dr. Schulz testified that respondent's failure to document C.A.'s subjective complaint and

history of present illness for his shoulder and ankle injury, such as the duration, intensity, and mitigating and aggravating factors to the pain he experienced constitutes a simple departure from the standard of care. Additionally, he opined that respondent's failure to document the circumstances of respondent's low heart rate and high BMI by documenting his state of physical fitness or other explanation constituted a simple departure from the standard of care. By comparison, Dr. Johnson testified that respondent's low heart rate and high BMI were simply of no consequence particularly because C.A. was a young, physically fit man, and that a physician is simply not required to document such information. With regard to respondent's failure to document C.A.'s history of present illness, Dr. Johnson opined that while a physician would be expected to ask the questions of the patient about the duration, intensity, and mitigating and aggravating factors to the pain, there is no obligation to record such information in the medical record. Dr. Johnson even opined that the physician had no obligation to record in the medical records information regarding medications that the patient is taking. Dr. Johnson's opinions regarding what information needs to be recorded in a patient's medical records would seem to indicate that almost no information is required to be recorded from a patient visit. Dr. Johnson's testimony in this regard was simply less credible than the testimony of Dr. Schultz.

16. With regard to the documentation of medical records for patient S.A. Dr. Schulz testified that respondent's failure to document S.A.'s subjective complaints and history of present illness on many of the progress notes from the two years during which S.A. was treated by respondent constituted a simple departure from the standard of care. Dr. Schulz discussed examples of S.A.'s medical records showing that in some cases the reason for the visit contradicted information in other portions of the medical record, such as when S.A. complained of frequent urination and in another portion of the progress note it was written that the patient denied frequent urination. Dr. Schultz's further opined that most of the patient records for S.A. contained the same review of system's information, likely from repopulation from the software, indicating that during each visit all of those questions were asked and answered when they were not. Dr. Schultz characterized these problems as a simple departure from the standard of care. By comparison, Dr. Johnson opined that, as with patient C.A. and all patients, there is no requirement that respondent provide information regarding the subjective complaint or history of present illness for each visit. Dr. Johnson also opined that there is no issue with the repopulation of the review of systems information for each patient visit because most physicians know not to trust that information because it is an electronic records issue. Dr. Johnson also stated that he does not use or trust electronic records in his practice despite the fact that about 80 percent of physicians in southern California do. Given Dr. Johnson's lack of experience regarding the use of electronic records, his opinion is less credible than Dr. Schultz on this issue and again, would indicate that almost no information needs to be recorded, making it less credible than Dr. Schultz's opinions.

17. With regard to the unauthorized disclosure of confidential patient information from one patient to another, respondent admitted that this occurred although she had no knowledge of it until about April 2015, after which she immediately took steps to correct the problem, including training her staff on HIPAA issues. Dr. Schultz opined that this

unauthorized disclosure of confidential medical information constituted a simple departure from the standard of care. By comparison, Dr. Johnson opined that the unauthorized disclosure of confidential information was simply a regulatory issue and was not a departure at all from the standard of care because this is not a standard of care issue. Dr. Johnson likened this problem to keeping the floor from being too slippery in the office. However, there is no doubt that the obligation of a physician in the practice of medicine to protect patient-physician confidentiality is critical. To compare that obligation to keeping the floor from being too slippery, or to characterize it only as a "regulatory issue" borders on absurd. Again, Dr. Schultz's opinion that these unauthorized disclosures constitute a simple departure from the standard of care is more credible than Dr. Johnson's opinion that the unauthorized disclosures do not constitute a departure from the standard of care at all.

Cause Exists to Impose Discipline on Respondent's License

18. Cause exists under Business and Professions Code section 2234, subdivision (b), to impose discipline. Clear and convincing evidence established that respondent engaged in gross negligence with respect to her care and treatment of patient C.A. by performing a TB skin test on C.A. when it was not indicated and then failing to have patient C.A. return for an interpretation of the TB test.

19. Cause exists under Business and Professions Code section 2234, subdivision (c), to impose discipline. Clear and convincing evidence established that respondent engaged in repeated acts of negligence with respect to patients C.A., S.A.., G.G., and E.T., by performing a TB skin test on C.A. when it was not indicated and then failing to have patient C.A. return for an interpretation of the TB test; by providing patient C.A. with a copy of patient G.G.'s medical record and patient C.F.A.'s medical record without written consent from patients G.G. or C.F.A.; by providing patient S.A. with a copy of patient E.T.'s medical record without written consent from patient E.T.; by failing to adequately document a history of present illness in patient C.A.'s medical records; by failing to adequately document a subjective complaint and history of present illness in patient S.A.'s medical records; and by using default information in the review of systems portion of S.A.'s medical record indicating that certain questions and responses were given when they were in fact not asked or answered during the examination.

20. Cause exists under Business and Professions Code section 2266, subdivision (c), to impose discipline. Clear and convincing evidence established that respondent maintained inadequate or inaccurate medical records with respect to patients C.A. and S.A., by failing to adequately document a history of present illness in patient C.A.'s medical records; by failing to adequately document a subjective complaint and history of present illness in patient S.A.'s medical records; and by using default information in the review of systems portion of S.A.'s medical record indicating that certain questions and responses were given when they were in fact not asked or answered during the examination.

21. Cause exists under Business and Professions Code section 2234 to impose discipline. Clear and convincing evidence established that respondent engaged in general

unprofessional conduct with respect to her care and treatment of patient C.A. by performing a TB skin test on C.A. when it was not indicated and then failing to have patient C.A. return for an interpretation of the TB test, and failing to document the TB test in patient C.A.'s medical records.

Application of Disciplinary Guidelines

22. California Code of Regulations, title 16, section 1361, provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). Under the Guidelines:

23. The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

24. Under the Disciplinary Guidelines, the minimum discipline for gross negligence, repeated negligence, and failure to maintain adequate medical records is a stayed revocation for five years. The maximum discipline is revocation. Among the conditions of probation, the guidelines recommend a clinical competence assessment program, a practice monitor, and solo practice prohibition.

25. Respondent has had no history of prior discipline and has a long history of providing competent medical care in a highly underserved population of patients. She has a great reputation in the community and as a physician. Multiple physicians in her community praised her professionalism, work ethic and quality of patient care. Respondent has taken steps to address her issues with medical record documentation by completing the PACE medical records course. Additionally, she has taken steps to correct the problem of unauthorized disclosure of confidential medical information by training her staff on HIPAA issues and has had no problems regarding such disclosures since doing so. Respondent is encouraged to continue her efforts in this regard. However, upon consideration of all the evidence in this matter, public protection dictates that a probationary term with appropriate terms and conditions is the appropriate discipline under these circumstances.

26. Respondent has practiced medicine for almost 30 years. She appeared knowledgeable and technically competent. However, the absence of meaningful introspection and continued denial regarding the treatment of patient C.A. vitiates any claim that she has a clear understanding of her deficiencies as to indicate that reoccurrence is unlikely.

27. Although it is a close decision, the public will be protected by placing respondent's certificate on probation for five years, with requirements that she complete

educational, medical recordkeeping, and ethics courses. The additional optional conditions recommended in the guidelines including the full clinical competence assessment, and supervision requirements are not appropriate for the circumstances of this case and are therefore not required for public protection. The allegations in this matter do not involve issues related to the supervision of others, or respondent's clinical competence, accordingly the requirement related to supervision of others and clinical competence assessment is not necessary for public protection. It is hoped that the probation requirements will remediate some of respondent's deficiencies and ensure that respondent practices in a safe and professional manner.

ORDER

IT IS HEREBY ORDERED that respondent's Physician's and Surgeon's Certificate, No. A 48353 is revoked. However, the revocation is stayed, and respondent is placed on probation for five years from the effective date of this Decision on the following terms and conditions:

1. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 16 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category 1 certified, limited to classroom, conference, or seminar settings. The educational

program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 40 hours of CME per year of which 16 hours were in satisfaction of this condition.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

6. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit. Respondent shall comply with the board's probation unit and all terms and conditions of this decision.

Address Changes. Respondent shall, at all times, keep the board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice. Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California. Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the board or its designee in writing 30 calendar days prior to the dates of departure and return.

8. INTERVIEW WITH THE BOARD, OR ITS DESIGNEE. Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

9. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the board or its designee shall not be considered non-practice and does not relieve respondent from complying with all

the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

10. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. LICENSE SURRENDER. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of her license. The board reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

12. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the

board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the board or its designee no later than January 31 of each calendar year.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

DATED: October 16, 2017

Debra D. Nye-Perkins

DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Mervat Gamil Kelada, M.D.** **1001 Blair Avenue** **Calexico, CA 92231** **Physician's and Surgeon's Certificate No. A48353,** Respondent.	Case No. 800-2014-006080 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 18, 1990, the Medical Board issued Physician's and Surgeon's Certificate No. A48353 to Mervat Gamil Kelada, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded and ordered to complete relevant educational courses, or have such other action taken in relation to discipline as the Board or an administrative law judge deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"...

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"...."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected her Physician's and Surgeon's License No. A48353 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that she committed gross negligence in her care and treatment of patient C.A. as more particularly alleged hereinafter:

Patient C.A.

9. On or about June 17, 2014, patient C.A. presented to respondent's office with complaints of pain to his shoulder and ankle. Patient C.A.'s vital signs were taken, and a heart rate of 47 was documented in his medical record. After a physical examination, respondent diagnosed patient C.A. with a sprain and strain of his shoulder and upper arm and ankle. Respondent referred patient C.A. to obtain x-rays of his shoulder and ankle and requested a follow-up visit in one week. Patient C.A.'s medical record for this visit does not contain any information regarding the severity or duration of the pain patient C.A. was experiencing in both his shoulder and ankle, and his heart rate of 47 was not addressed.

10. On or about June 20, 2014, patient C.A. presented to respondent's office to obtain the results of his x-rays. Shortly after entering the examination room, respondent began to fill a syringe and rubbed patient C.A.'s arm with an alcohol towelette. When patient C.A. asked respondent what she was doing, respondent told patient C.A. that he needed a tuberculosis (TB)

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test.[1] Patient C.A. tried to tell respondent that he was there for his x-ray results, but respondent proceeded to give patient C.A. the TB test.

11. After completing the injection, on or about June 20, 2014, respondent told patient C.A. that he was done and needed to return in nine (9) days. Patient C.A. reiterated that he was there for his x-ray results. Respondent then told patient C.A. that it was "just a TB test" and that nothing would happen.

12. The medical records for patient C.A. for his visit to respondent on or about June 20, 2014, do not reflect that he was administered a TB test.

13. At the same visit, on or about June 20, 2014, respondent referred patient C.A. to an orthopedic surgeon and requested a follow-up visit in four (4) weeks. Prior to leaving respondent's office, patient C.A. obtained a copy of his orthopedic referral from the front desk. The back side of the referral that was handed to patient C.A. contained a portion of the electronic medical record of another patient, patient G.G., for treatment rendered to patient G.G. by respondent on or about May 27, 2014.

14. On or about October 11, 2015, respondent was interviewed by an investigator from the Division of Investigations. At that interview, respondent claimed to have independent recollection of patient C.A., and repeatedly denied giving patient C.A. a TB test.

15. Documents provided to the Board show that the patient who was scheduled to see respondent directly after patient C.A. was there for a TB test.

16. Respondent committed gross negligence in her care and treatment of patient C.A. which included, but was not limited to, performing a TB skin test on patient C.A. when it was not indicated, and then failing to have the patient return for an interpretation of the test.

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[1] A TB test is used to determine if someone has developed an immune response to the bacterium that causes tuberculosis. The standard TB test is administered by injecting a 0.1 mL of liquid containing 5 tuberculin units purified protein derivative (PPD) into the top layers of skin of the forearm. The results of the test are reviewed 48-72 hours after the injection to determine the presence or absence of localized swelling.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

17. Respondent has further subjected her Physician's and Surgeon's License No. A48353 to disciplinary action under section 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in in her care and treatment of patients C.A., S.A., G.G., and E.T., as more particularly alleged hereinafter:

18. Paragraphs 8 through 15, above, are hereby incorporated by reference and realleged as if fully set forth herein.

Patient S.A.

19. Between in or around 2012 and 2014, respondent provided care and treatment to patient S.A. as her primary care physician.

20. On or about December 10, 2012, patient S.A. presented to respondent's office seeking a referral for a dermatologist regarding a growing mole on her right upper eye lid. In the medical record for this visit, respondent failed to document the nature, duration, or appearance of the mole, and in the physical examination portion of the record, respondent noted, "no suspicious lesions."

21. On or about June 13, 2014, patient S.A. presented to respondent's office with complaints of left breast pain and left abdominal pain. In the medical record for this visit, respondent failed to document the duration and severity of symptoms, precipitating and ameliorating factors, other temporally-associated symptoms, and the presence or absence of other potentially-related symptoms.

22. On or about July 16, 2014, respondent's office provided patient S.A. a copy of the diagnostic findings from her recent mammography exam. The back side of the document provided to patient S.A. contained a portion of the electronic medical record of patient E.T., for treatment rendered to patient E.T. by respondent on or about July 11, 2014.

23. On or about August 19, 2014, patient S.A. presented to respondent's office with complaints of frequent urination. At that visit, patient S.A.'s heart rate was not taken or

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documented, despite the fact that respondent diagnosed patient S.A. with essential hypertension and prescribed her beta blocker medication.

Patient G.G.

24. On or about May 27, 2014, patient G.G. presented to respondent's office after receiving positive pregnancy results. At the conclusion of the exam, respondent referred patient G.G. to a gynecologist and requested a follow-up visit in three (3) months.

25. Patient G.G. and patient C.A. do not know each other, and patient G.G. did not provide consent to respondent to release any of her medical information from that visit to patient C.A.

Patient E.T.

26. On or about July 11, 2014, patient E.T. presented to respondent's office for an INS physical. At the conclusion of the exam, respondent referred patient E.T. for diagnostic imaging and requested a follow-up visit in 2 to 3 days.

27. Patient E.T. and patient S.A. do not know each other, and patient E.T. did not provide consent to respondent to release any of her medical information from that visit to patient S.A.

28. Respondent committed repeated negligent acts in her care and treatment of patients C.A., S.A., G.G., and E.T., which included but was not limited to, the following:

(a) Performing a TB skin test on patient C.A. when it was not indicated, and then failing to have the patient return for an interpretation of the test.

(b) Failing to adequately document a subjective complaint or history of present illness in patient C.A.'s medical records.

(c) Failing to document a subjective complaint or history of present illness in patient S.A.'s medical records;

(d) Using default review of systems and physical exam language in patient S.A.'s medical records.

(e) Providing patient C.A. a copy of patient G.G.'s medical record without consent from patient G.G.

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(f) Providing patient S.A. a copy of patient E.T.'s medical record without consent from patient E.T.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

29. Respondent has further subjected her Physician's and Surgeon's License No. A48353 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records relating to her provision of services to patients C.A. and S.A., as more particularly alleged in paragraphs 8 through 28, above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

30. Respondent has further subjected her Physician's and Surgeon's License No. A48353 to disciplinary action under sections 2227 and 2234 of the Code, in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 8 through 29, above, which is hereby incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A48353, issued to respondent Mervat Gamil Kelada, M.D.;

2. Revoking, suspending or denying approval of respondent Mervat Gamil Kelada, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

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3. Ordering respondent Mervat Gamil Kelada, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 7, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant